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September 10, 2007

MEMORANDUM

TO: Legislative Oversight Committee
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
MH/DD/SAS Professional and Stakeholder Organizations
NC Association of County DSS Directors

FROM: Mark Benton
Mike Moseley

SUBJECT: Implementation Update #34: Various Updates

Technical Assistance

The DMA Behavioral Health Policy Unit has created a Training and Technical Assistance Team to address the volume of provider inquiries for Medicaid service implementation assistance. This team will work directly with LME and Provider staff. The intent of the team is to better ensure the consistent implementation of DMA requirements and service definitions. The Training and Technical Assistance Team members are:

Marie Britt, RNBC, MS (910) 674-4226
Simone Chessa, LCSW (919) 471-3612
Bert Bennett, PhD (336) 724-4539

These individuals may be contacted to provide Medicaid 101 training, provide information on EPSDT policy application, answer questions regarding service definitions and provide technical assistance regarding specific consumer/family situations. DMA and DMH/DD/SAS are working together to continue updates of question and answer documents published on the DMH/DD/SAS web site. We will be working closely with the LMEs to coordinate activities and to develop a system of ongoing support for providers.

DMH/DD/SAS remains your contact point for inquiries related to State-funded services, DMH/DD/SAS Rules, Provider Endorsement standards, LME performance, Screening, Triage & Referral (STR), staff qualifications and training requirements, Person Centered Planning (PCP) and records and documentation. The 12-member LME Systems Performance Team focuses on: 1) monitoring LMEs specific to the DHHS/LME Performance

Contract functions; 2) monitoring outcome performance measures as documented in the DMH/DD/SAS quarterly Community System Progress Indicator Report; and 3) providing assistance to LMEs in response to the outcomes resulting from this monitoring.

Any inquiries concerning service authorization should be directed to the ValueOptions (VO) Provider Relations Department at **(888) 510-1150;** payment issues to EDS Provider Services at **(800) 688-6696.** If their staff cannot answer the concerns, please contact the DMA Behavioral Health Unit at (919) 855-4290. Other DMA Sections that may be of assistance are DMA Client Eligibility at (919) 855-4000 and Provider Enrollment at (919) 855-4050. DMA Program Integrity Unit coordinates all payment recoupment issues.

Further Clarification of STR for Medicaid Recipients

As presented in the Access to Care training and the related *Implementation Update #32*, Screening, Triage and Referral functions may not be used to deter any services for Medicaid recipients. Only DMA and its authorized agents (ValueOptions, Murdoch, EDS) can determine that a Medicaid consumer does not meet the criteria for a Medicaid covered service at the time of level of care or prior approval determinations. Potential clients and families must be referred to the requested provider and service, even if the LME qualified professionals determine that it is unlikely that the client may qualify for such services. Therefore, LMEs must provide access to all requested services that are available for Medicaid recipients.

This is especially important in the LME management of services for individuals with developmental disabilities. Referral for a comprehensive clinical assessment and for Targeted Case Management services must be made for individuals with mental retardation or developmental disabilities. The TCM provider must be aware and make referrals for other Medicaid services that may include personal care services, durable medical equipment, assistive technology and other CAP programs such as CAP-C or CAP-DA. At no point in time may an LME or provider limit consumer requests for services.

Payment Changes

There have been numerous concerns with the policy and claims adjudication that have had an impact on providers of specific mental health and substance services. Below is a status report of the revisions made to the policy:

- Targeted Case Management (TCM) – There have been three aspects of payment for TCM that have been addressed. These are as follows:

  - TCM payments that exceed the $6,000 limit per recipient – Virtually all payments for services that exceeded this monetary limit have been resolved, and payment was expected by July 30, 2007. Letters are being mailed to LMEs and the specific providers with the approved services and payments identified.
  - TCM referral numbers for children age 3 (past the third birthday month) - 4 – The edit that requires the CDSA referral number for this population has been removed to allow the LME, on behalf of TCM providers, to submit payment without this requirement.
  - Any TCM claims that have received the denial, **EOB 1649,** should be resubmitted to EDS for reprocessing.

  TCM Service Reimbursement – This service remains reimbursed through LMEs, and the information now available from VO and EDS to LMEs must be distributed to applicable providers. Every LME is reimbursed for this service, and it is their responsibility to convey this information to every applicable provider. DMH/DD/SAS has offered guidance in how to address this responsibility by allowing providers to use the LME provider number and bill directly for all services they have delivered. There is no financial liability to the LME for this process. Financial liability rests with the provider.

- Licensed Substance Abuse (SA) Providers – Effective May 2007, DMA expanded the billing of CPT codes for Licensed SA Providers. Although the enrollment procedures and assigned provider specialty

may include Certified SA Specialists, payment for these new codes is not allowed. This policy is limited to Licensed SA professionals only.

- Intensive In-Home Providers - Providers that have received the denial, **EOB 3746,** on a claim for Intensive In-Home (H2022), Substance Abuse Comprehensive Outpatient Treatment (H2035), or Substance Abuse Intensive Outpatient Program (H0015) should resubmit the claim(s) to EDS for reprocessing.

EPSDT Approved Payment

Previously, providers were directed to submit unprocessed claims to the DMA Behavioral Health Policy Unit for payment of EPSDT approved services. This has posed challenges to the payment system for processing. Upon recognizing these problems, DMA has worked with EDS to revise its data system to be able to pay directly the majority of these claims; these system changes are expected to be fully implemented by September 2007. During the interim, payment for of these services require manual overrides by EDS, which takes approximately 6-8 weeks. For overrides to occur, copies of the denied claim Remittance Advice (RA) and authorization letters must be submitted to DMA.

Clarification of Prior Approval Changes

There have been a number of questions concerning the authorization timelines for Targeted Case Management. The following is designed to assist in clarification of expectations:

- Initial authorization of TCM services for **non-CAP recipients** should occur on the CTCM form accompanied by the Introductory or full PCP. There is an 8-hour unmanaged benefit for initial authorization for individuals who have never received mh/dd/sas services. Reauthorization for non-CAP recipients should occur on the CTCM form with a full PCP or PCP update. ValueOptions will authorize up to 90 days of service.
- Initial authorization of TCM services for CAP recipients should occur on the CTCM form accompanied by the Plan of Care. The Plan of Care should clearly reflect a case management plan with specific outcomes. Initial authorization will be good up to the Continued Need Review, with reauthorization occurring at CNR. Authorization for TCM will be up to 60 hours or 240 units per year. Requests for additional units beyond the 240 units will require a Plan of Care Update with clear justification for additional units of service.

Providers must ensure that submissions to ValueOptions for Prior Approval are submitted to the correct Fax number. This is critically important to assure receipt. Below are the appropriate fax numbers based upon the type of service being requested:

Facility Based Crisis, Inpatient, Mobile Crisis: 919-461-9645
Child Residential/TFC & EPSDT: 919-461-0679
Other MH/SA: 919-461-0599
CAP/TCM: 919-461-0669

Retroactive Client Eligibility for Medicaid

ValueOptions may only provide retroactive authorization based on consumer Medicaid eligibility not to exceed 90 days. Providers are responsible for financial intake procedures and must be knowledgeable of changes in Medicaid recipient status. The provider should seek authorization from the LME for state funding during this time period and, upon retroactive Medicaid eligibility, submit to ValueOptions the ITR, PCP(s) covering the time period and copies of the LME authorization letters, if applicable. They will then evaluate this information and make a separate determination as to medical necessity. Assuming the LME has authorized payment of state funds, the provider should anticipate recoupment of funds by the LME following Medicaid payment. Please note that nothing in this process is intended to create an entitlement to state-funded services. The LME will make its own medical necessity determination and evaluate its funding ability prior to authorizing state-funded services.

Community Support Service Providers
EDS is currently working on the programming for recoupment and repayment of the community support claims paid during April 2007. Claims will automatically be recouped and repaid at the correct rates for the dates of service those rates were effective. An exact date for the recoupment/repayment process is not known at this time, since EDS is still in the programming phase. DMA will keep you informed as this recoupment/repayment project moves to completion. Providers are able to submit adjustment claims through the web portal by using the previously published instructions. Thank you for your patience.

Service Rate Re-Evaluations
As a part of the overall review of MH/DD/SAS Transformation and, specifically, the implementation of new service definitions, DMA is engaging in the re-evaluation of rates for specific services. DMA and DMH/DD/SAS have prioritized the re-evaluation of MST, Intensive In-Home, Community Support Team, ACTT and SAIOP services for review in 2007. The majority of these service rates were based upon a prospective model of anticipated costs. Now there is the opportunity to base these rates upon the actual cost of service implementation. Providers have been identified for participation in this process based upon recommendations from DMH/DD/SAS, LMEs and provider associations. Providers that choose to participate will undergo review of actual cost reporting to establish potentially new rates that will support this service delivery.

Medicaid Appeals
When a reduction, denial, or termination of services occurs for a Medicaid eligible consumer, ValueOptions will issue a written notice to the service recipient and provider that explains the reason(s) for the adverse action and how to appeal the decision. If the consumer chooses to appeal the decision, he/she or his/her legal representative has the choice to appeal the decision to either the Department of Health and Human Services (DHHS) Hearings and Appeals Office to request an informal appeal or to the Office of Administrative Hearings (OAH) to request a formal appeal. The appeal request must be filed in accordance with the instructions provided in the consumer's notice. The hearing office, either DHHS Hearings and Appeals or OAH, will notify ValueOptions that an appeal has been requested. Services should be continued at the level being provided at the time of the denial, reduction, or termination or at the level requested by the provider, whichever is lower. Additional identical requests cannot be processed until the appeal is heard. Providers should continue the service until notified of the outcome of the appeal

As the appeal is processed, ValueOptions will contact the provider to request copies of the medical record. The purpose of this information is to determine if ValueOptions should modify the prior authorization decision. It is critical that providers submit this information as soon as possible to attempt to reconcile the situation on behalf of the recipient.

Addition to Enhanced Services Implementation Update #29
In the first paragraph of Enhanced Services Implementation Update #29, three billing codes were identified as being billable by provisionally licensed psychologists, provisionally licensed social workers, marriage and family therapists in the associate-licensure status and board-eligible professional counselors. A fourth billing code, H0031 (Mental Health Assessment) was inadvertently omitted. The aforementioned clinicians may submit Medicaid claims through participating Local Management Entities for these four billing codes:

- H0001 (Alcohol and/or Drug Assessment),
- H0004 (Behavioral Health Counseling – Group, Family, or Family with Client),
- H0005 (Alcohol and/or Drug Group Counseling), and
- H0031 (Mental Health Assessment).

Please note, provisionally licensed psychologists, provisionally licensed social workers, marriage and family therapists in the associate-licensure status and board-eligible professional counselors shall not function in the role of a Qualified Professional for the purpose of conducting a Diagnostic Assessment. However, these same

clinicians are now eligible to function as a Qualified Professional in the provision of Intensive In-Home services.

Addition to Enhanced Services Implementation Update #32 Introductory Person-Centered Plan:
It is necessary to clarify that the information obtained and submitted for the initial authorization of services in the Introductory Person-Centered Plan is now consistent with the UR process at both the LME and ValueOptions. The same information will be submitted for utilization review and authorization at ValueOptions for Medicaid services and at each LME for state-only services. There should be no additional LME requirements for data related to initial authorization of services beyond those noted in Implementation Update #32 as the Introductory Person-Centered Plan.

Please e-mail any questions regarding this Implementation Update to DMH/DD/SAS at contactdmh@ncmail.net. Please put "Implementation Update #33" in the subject line to assure speedy delivery to the appropriate source.

cc: Secretary Dempsey Benton
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